	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Constable for West Midlands Police** **2. West Midlands Police and Crime Commissioner** **3. Home Secretary - Rt Hon Priti Patel MP**
1	**CORONER** I am Louise Hunt, Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 29/03/2019 I commenced an investigation into the death of Karen Jane Burns. The investigation concluded at the end of an inquest on 12th August 2019. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was found hanging from a basketball net at the park on Hallmoor Road in Lea Hall Birmingham at 06.15 on 23/03/19. She left a note indicating her intentions. At 00.19 that day her ex-partner had contacted 101 to report that the deceased had threatened to smash up his car and then kill herself. The call was graded as P3 – 8 hour response despite a previous suicide attempt in April 2018. The call should have been graded as a P2 with a 1 hour response time however due to the large number of emergency calls that evening it is unlikely that officers would have responded to the call before she was found in the park. Following a post mortem the medical cause of death was determined to be: SUSPENSION BY A LIGATURE AROUND THE NECK
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. I heard evidence at the inquest that this call was graded incorrectly. It should have been graded as a P2 call with a response time within 60minutes. I also heard evidence to confirm that the large number of P1 calls that evening meant that even if the call had been correctly graded it would not have been answered as all available resources were required for the P1 calls (15 minutes response). The evidence confirmed that nearly all the P2 and P3 calls went unanswered that night. This raises a serious concern about the amount of resources available to West Midlands Police. Urgent attention is needed to address the resources available, particularly at night, as current resources are unable to deal with the large volume of cases the Force is expected to deal with.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th October 2019. I, the coroner, may extend the period.

	Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the family. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	12/08/2019 Signature  Louise Hunt Senior Coroner **Birmingham and Solihull**